July 29, 2002

Office of the Secretary
Federal Communications Commission
445 12th Street, SW, Room TW-A325
Washington, DC 20554

Dear Chairman Powell:

The Federal Regional Council (FRC), Region IX, is a consortium of twenty-one different federal Departments and Agencies based in San Francisco working in partnership to better serve the public. The FRC's Outer Pacific Committee (OPC) has a goal of working together to improve the health and social status of residents in the three U.S. Flag Territories and the three Freely Association States in Region IX. OPC's work has enabled it to be regarded as an important regional resource by the State Department's Office of Compact Negotiation, the General Accounting Office, and the Department of the Interior's Interagency Group on Insular Areas.

In this global age, our Committee considers access to affordable telecommunications for health care essential to protect not only the residents of these U. S. territories, but all U.S. citizens. However, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands face significant geographic isolation, poverty and health professional shortages, as well as high rates of diseases compared to the rest of the United States. Despite extreme need, these jurisdictions have not been able to benefit from the FCC's Universal Service Rural Health Care Program, even though their telecommunication providers and consumers contribute to the Universal Service Fund.

As outlined in the Committee's enclosed Reply Comments to "WC Docket No. 02-60 – In the Matter of Rural Health Care Support Mechanism", two simple changes could greatly benefit the territories. First, designate Honolulu, Hawaii, which is the nearest urban center with specialty and tertiary care and with health professions training and continuing education programs to each of the territories, as the "urban area" for determining the Rural Health Care subsidy. Second, calculate the American Samoan subsidy as is currently done for Alaska, where many villages are also dependent on satellite.

The OPC believes the Commission's actions on this issue will mean that more of the limited health care dollars available in these U.S. territories will be able to be utilized for health and public health services, serving a greater number of people and more adequately protecting the public's health. Given the geographic isolation and time differences, the territories also lack access to timely, relevant health and public health technical assistance and administrative services. Our Committee believes that reasonable telecommunication costs will enable these jurisdictions to more easily communicate with

Federal program officials to obtain health-related technical assistance both now and during natural and man-made disasters.

Thank you for the opportunity to provide these comments.

Sincerely,
Emory M. Lee

Chair, Outer Pacific Committee
50 United Nations Plaza, Room 431
San Francisco, CA 94102-4999

Enclosure

Before the
Federal Communications Commission
Washington, DC 20554

In the Matter of	)	
	)	
Rural Health Care Support	)	WC Docket No. 02-60
Mechanism	)	

Comments of the Outer Pacific Committee, Federal Regional Council, Region IX

These Reply Comments from the Federal Regional Council's Outer Pacific Committee (OPC) are in response to the Federal Communication Commission's (FCC) Notice of Proposed Rulemaking in the matter of the Universal Service Rural Health Care Support Mechanism, FCC-02-122, (WC Docket No. 02-60). These Reply Comments primarily address Section III.C.4. – "Insular Areas", although some comments also address Section III.D.3.c. "Encouraging Partnerships with Clinics at Schools and Libraries", Section III.C.1 - "Interpretation of Similar Services and Urban Area", and Section III.C.2 – "Urban Area". They address comments submitted by:

PEACESAT/ Norman Okamura and Christina Higa
Department of Veteran Affairs
Kingston eHealth
American Samoa Telecommunications Authority
American Samoa Medical Center Authority, Taufete'e John Faumuina, CEO
Guam Memorial Hospital Authority, Dr. David Shimizu, Administrator
Guam Department of Public Health and Social Services, Dennis G. Rodriguez, Director
Guam Department of Health and Substance Abuse, Auroroa F. Cabanero, Acting Director
PCI Communications
IT&E Overseas, Inc., John Borlas, P.E.
Center for Telemedicine Law
American Telemedicine Association
Western Governor's Association
The National Telecommunications Cooperative Association
Alaska Federal Health Care Access Network

The OPC commends the FCC for issuing this Notice of Proposed Rulemaking that provides an opportunity to comment on the issues affecting the regulations governing insular jurisdictions. However, we must also note our concern that five years have

passed since the original order[1] was issued and to date, the most rural, remote and needy jurisdictions of our nation – American Samoa, Guam and the Commonwealth of the Mariana Islands - have yet to benefit from the Rural Health Provider program, even though their telecommunication carriers and consumers pay into the fund. For this reason, the OPC respectively submits the following comments and urges the Commission to revise its interim rule governing the insular areas, in particular the Pacific Basin territories.

Some of the Federal agencies represented on the OPC provide funds for health services and health system infrastructure in the insular areas (e.g., the Health Resources and Services Administration, HHS). The programs of other agencies, such as the Department of Education's Vocational Rehabilitation program and the Head Start program of the Administration on Children and Families (ACF), HHS are directly affected by health conditions in the insular areas. For example, many of the recipients eligible for vocational rehabilitation services in Guam have disabilities related to diabetes (i.e., blindness and amputations); in ACF's Head Start program, all children receive health, dental and oral health services in a child development environment. Additionally, ten percent of all Head Start enrolled children are children with disabilities and qualify for special health services. Therefore, prompt action on the part of the Commission to address the insular areas is of paramount importance to members of this Committee.

OPC'S comments will specifically address the three United States Flag Territories in the Pacific Basin – American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam - whose consumers and telecommunication carriers pay into the Universal Service Fund. It is our understanding that the situation for the Virgin Islands is similar, but is outside our geographic area of expertise and program administration authority.[2]

In Docket 02-60, the Commission seeks further comments on whether it has the authority under section 254(h)(2)A to designate an out-of-state urban locale as the relevant urban benchmark for insular areas. We believe it does, as will be discussed below.

First, however, in order to understand the comments regarding insular areas provided to the Commission by the above noted institutions and individuals, it is useful to review the current rule for insular areas, a rule which prevents the U.S. territories of Guam,

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[1] Report and Order – CC Docket No. 96-45, Released: May 8, 1977

[2] In addition to the three Pacific Basin flag territories, the Federal government has special relations with three other Pacific Basin jurisdictions. The Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia (Yap, Pohnpei, Chuuk, and Kosrae), through Compacts of Free Association (i.e., joint Congressional-Executive agreements with the U.S. government), have special rights and participate in several Federal programs, including grant programs, in exchange for exclusive use of their land for military purposes. These jurisdictions are also called the U.S. Freely-Associated States (FAS). Although we believe these nations would also greatly benefit from participating in the Rural Health Provider program, our reply comments will relate to the immediacy of addressing the situation faced by Guam, American Samoa, CNMI and the Virgin Islands, because the FAS jurisdictions do not have the same standing with the U.S. government as the flag territories and because they do not pay into the Universal Service fund. OPC encourages the Commission however, to further explore how and whether the program could be expanded to the Freely Associated States, particularly in light of the Nation's need for an integrated network of health care providers.

American Samoa and CNMI from benefiting from the Universal Service Rural Health Care Support Mechanism. In 1997, the Commission, in order to implement the program in insular areas, designated "urban" areas in each jurisdiction for the purpose of calculating the urban-rural differential on which to base the subsidy. However, the Commission used a different definition of 'urban' for the territories than was used for the other 50 states, and the definition unfortunately did not take into account the rural, isolated nature of these jurisdictions.

Definition of Urban:
In 1997, the Commission chose to define the phrase 'nearest large city' to mean: "the city in the state with a population of at least 50,000, nearest to the rural health care provider's site…".[3] The Commission stated: "Like the Joint Board, we conclude that telecommunication rate in the nearest large city are a reasonable proxy for the 'rates…in urban areas in a State.' We believe that cities with populations of at least 50,000 are large enough that telecommunications rates based on costs would likely reflect the economies of scale and scope that can reduce such rates in densely populated urban areas. We also choose the 50,000 city size because an MSA, as defined by OMB, is based in part on counties with cities having a population of 50,000 or more, and *every state has at least one MSA with a city that size*."[4]

If one reviews the rational for the Joint Board's choice of a city of 50,000 as the city of comparison, it was based on[5]:

- a city of that size being a reasonable proxy for the rates in urban areas in a state;
- a city of that size having the range of health and public health services (including medical specialties), and health professions educational programs that the Congress was seeking to make available to rural areas through the Rural Health Care Universal Service Support Mechanism.[6]
- 'all' states having a city of that size.

However, even though for the purposes of the Act, "state" was defined to include the 50 states and the U.S. territories, no Pacific Basin Flag Territory had a city of 50,000. Indeed, the Commission itself acknowledged: "…that the unique geographic and demographic circumstances of CNMI and Guam – including their uniformly rural character, their lack of a city with a population as large as 50,000, or indeed any real urbanized population centers, … and the relatively small size and low density of their populations – render the mechanisms we adopt under section 254(h)(1)(A) ill-suited to

[3] Report and Order - CC Docket No. 96-45, Section XI.D.2.b. ¶669. Adopted May 1997 and Released May 8, 1997.
[4] Report and Order - CC Docket No. 96-45, Section XI.D.2.b. ¶670. (emphasis added)
[5] The Joint Board's recommendations were based, in part, on recommendations of the FCC-established Advisory Committee on Telecommunications and Health Care. The Advisory Committee, created in 1996 to advise the FCC and the Joint Board on telemedicine and in particular on the provisions of the 1996 Telecommunications Act relating to rural health care providers, released a report in 1997. The Committee was composed of 38 individuals with expertise in health care, telecommunications and telemedicine.
[6] Report and Order – CC Docket No. 96-45, Section XI. B. ¶617 & ¶618.

these territories without modification."[7] Likewise for American Samoa and the U.S. Virgin Islands, the Commission stated: "We recognize … that American Samoa and the U.S. Virgin Islands, like CNMI and Guam, are relatively isolated, have small populations and have limited medical resources."[8]

Because the jurisdictions did not have a city of 50,000, and because the Commission felt it had insufficient information regarding the territories, it chose to designate what it termed "the largest population centers" as the "urban" area for the purpose of determining the amount of support.[9] In American Samoa, it designated the entire island of Tutuila as urban; in CNMI it designated the entire island of Saipan as urban; and in Guam it designated Agana, the capital, as urban. All other areas of the jurisdictions were deemed rural. To understand why these designations are, however, inappropriate, it is necessary to understand more about the isolation, geography, and medical/health resources in each jurisdiction.

Overall, the Pacific Basin flag territories face a degree of remoteness and rurality that is unknown in the mainland outside of Alaska. They face shortages of health professionals as well as health professions training programs and continuing education opportunities that are unparalleled in the fifty states. And, they contend with an extremely heavy burden of diseases and natural disasters. The geography, health services and health personnel situations in each jurisdiction are summarized below. More thorough descriptions are provided in Appendix 1.

Isolation: American Samoa, the closest of the three jurisdictions, lies 2,300 miles southwest of Hawaii and 4,150 miles from the continental United States. CNMI lies approximately 3,700 miles west of Hawaii and Guam approximately 3,800 southwest of Hawaii and 9,500 miles from Washington, D.C. Both Guam and CNMI are on the other side of the international dateline. American Samoa and CNMI are comprised of several islands and their land areas cover 77 square miles and 120 square miles, respectively. Guam is comprised of one island covering 209 square miles. The area covered by these islands is immense, as shown in the map below.

[7] Report and Order – CC Docket No. 96-45, Section IX. B. ¶694.
[8] Report and Order – CC Docket No. 96-45, Section IX. B. ¶695.
[9] Report and Order – CC Docket No. 96-45, Section XI.D.4. ¶696 & ¶697.

From: *Pacific Health Dialogue*, V(2), Sept. 2000, "Pacific Island Health Care Project; early experiences with a web-based consultation and referral network", D. A. Person. p.30.

The topography and settlement patterns of most of the inhabited islands of the jurisdictions are influenced by the volcanic origins of the islands – small villages and towns are scattered along the coastal areas and in valleys between mountainous areas. Travel is often slow due to windy roads that follow coastlines or traverse valleys. For example, on the island of Tutuila in American Samoa, over half the population resides more than an hour from the hospital.[10]

Health Personnel: All of the territories are classified by the U.S. Department of Health and Human Services as having Health Professional Shortage Areas (HPSAs) in primary care, dental and mental health. The designation means they lack an adequate supply of these types of providers.[11] The shortage of these providers is compounded by an almost complete lack of specialty providers, except for a small number on Guam, and this is further compounded by an almost complete absence of health professions training programs in the jurisdictions. The institutions of higher education in American Samoa and CNMI are limited to community colleges and the only health professions program offered at each is an associate-degree nursing program. However, recruiting and retaining faculty is difficult. The University of Guam is the only university in the territories. It offers a 4-year (BSN) nursing program. In the territories, there are no programs to train nurse practitioners or other primary care providers, and no programs to train allied health personnel.

Health Status: The territories also face unique health conditions. Not only do they contend with diseases seen in developing counties such as high rates of infectious

[10] Pacific Island's Health Data Matrix (December 2000), Pacific Island Health Officers Association.
[11] The Health Resources and Services Administration, HHS designates these shortage areas. It does not designate shortage areas for specialties because areas with shortages of primary care providers almost always have shortages of specialists, if specialists are available at all.

diseases (tuberculosis[12], Hepatitis B, and infectious skin diseases), they also deal with the chronic diseases of developed counties, such as diabetes and cardiovascular diseases.[13] Moreover in Guam and CNMI, because of migration from the U.S. Freely-Associated States[14] and other Asian countries, the health personnel and systems in these jurisdictions must be able to diagnose and treat diseases such as cholera, Hansen's disease (leprosy), dengue fever, malaria and respond to epidemics such as measles.[15]

These flag territory health systems and personnel not only face isolation, health personnel shortages, and diseases seldom seen on the mainland, but must also frequently respond to natural disasters. For example, Guam has been devastated by two typhoons within the last five years.[16] Moreover, Guam often serves as a resource for other more disadvantaged jurisdictions in its region, when it is called upon to assist them. Currently, even in the midst of responding to the devastating Typhoon Chata'an of July 2002, it has been providing assistance to Chuuk[17], which was devastated more severely than Guam by the recent tropical storm and whose resources are more meager than those of Guam.

Off-Island Care: Because the jurisdictions do not have access to specialty care, they are faced with providing off-island referral care for patients. In its 1999 comments to the Commission, the Federal Office for the Advancement of Telehealth, HRSA, HHS provided documentation of the high economic burden to the jurisdictions as the result of off-island care.[18] In some years, 25% of a jurisdiction's health care budget is used for off-island care, which unfortunately benefits only a small percentage of the population. Off-island care is not only expensive, but flights in and out of the jurisdictions are also very limited. For example, American Samoa is serviced by only two flights a week on Monday and Friday. Moreover, travel is costly – flights from American Samoa to Hawaii cost approximately $700 and from Guam to Hawaii $900-$1,200.

We believe it was precisely such isolated, rural, resource poor communities as the U.S. flag territories that Congress intended to support through the Rural Health Care Universal

[12] [45.5/100,000 in Guam compared to the U.S. rate of 6.8/100,000 (1998)]
[13] Pacific Basin Telehealth Report (June 2002 Draft), Pacific Basin Telehealth Consortium, University of Guam.
[14] The Compacts of Free Association Acts (see footnote 2) authorize unrestricted immigration of FSM, Palau and Marshalls citizens into the United States and its territories. Many individuals from the FAS have migrated to Guam and CNMI, which has placed an increased demand on health and educational services in these territories. [Department of the Interior-Office of Insular Affairs, *A Report on the State of the Islands*, www.doi.gov/oia/chapter4.html]
[15] Pacific Basin Telehealth Report (June 2002 Draft), Pacific Basin Telehealth Consortium, University of Guam.
[16] Typhoon Paka, which hit Guam in December 1997, had sustained winds of 150 miles per hour and gusts up to 236 miles per hour, the highest ever recorded. The July 2002 Typhoon Chata'an caused an island-wide power outage as well as well as a loss of water.
[17] Chuuk is one of the 4 states of the Federated States of Micronesia that has a Compact of Free Association with the United States.
[18] FCC Filing on Underserved Insular Areas, December 1999, Office for the Advancement of Telehealth, HRSA, HHS [http://telehealth.hrsa.gov/pubs/fccfil3.htm]

Service support mechanism. Congress enacted the program to provide affordable telecommunications services in such areas so that individuals and communities would be able to access specialty services, health professions training programs and public health services.

However, the interim mechanism established by the Commission for designating urban areas in each jurisdiction has meant that these flag territories have not been able to obtain affordable telecommunications services and therefore not been able to access needed specialty, educational and public health services:

> In American Samoa, the entire island of Tutuila was designated as urban. However, the overall nature of this island is rural. Moreover, specialty health services and health professions education programs, except for the two-year nursing program at the community college, are not available on Tutuila, even though the island was designated as urban because the majority of American Samoans live on the island.
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> In CNMI, the island of Saipan was designated as "urban". As in American Samoa, the island of Saipan is comprised of small villages and towns. The largest town on Saipan is Garapan, population 3,600. Thus, as with American Samoa, designating the island as urban does not enable the population to access specialty services and health professions training programs. That is, although it may enable a mid-level provider in a clinic on the island of Rota to confer with a primary care provider on Saipan, it does not provide the needed connectivity to specialty services and to health professions education programs.
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> On Guam, the Commission designated the capitol community of Agana (Hagatna), a community of approximately 1,100 residents, as the urban area and the rest of the island as rural. However, all calls on the island of Guam are local calls so there is no difference between the rates in Agana and the rates in villages on the southern tip of the island. Moreover, the types of services needed (i.e., specialty services and health professions education) are generally not available on Guam, except for a limited array of specialty services and the University of Guam's BSN nursing program.
>
> The closet U.S. urban center to these three territories in which specialty health services and the health professions training and continuing education programs are available is Honolulu, Hawaii.

Recommendations and Rationale:

The OPC recommends the following to enable the three U.S. Pacific Basin flag territories to benefit under the Universal Service Rural Health Care Support Mechanism:

1) Designate Honolulu, Hawaii as the nearest urban center for determining the Universal Service Rural Health Care subsidy. Honolulu is the nearest urban center to these three jurisdictions that has the specialty, tertiary and public health services, and the health professions training and continuing education programs that the Congress intended rural communities to assess under the program.

2) Using Honolulu as the urban center, calculate the subsidy for American Samoa as is currently done for villages in Alaska which are dependent on satellite. American Samoa is dependent upon satellite telecommunications. There is no undersea telecommunication cable between American Samoa and Honolulu.

We believe that the Commission has the authority to designate Honolulu, Hawaii as an "out-of-state" urban locale for setting the relevant urban benchmark for the Pacific Basin insular areas. We concur with others, as discussed below, on this issue.

The Committee's comments first address the inclusion of the territories in the Rural Health Care Support Mechanism and then the Commission's authority to make special provisions for the insular areas and in particular to designate an "out-of-state" urban area for the territories.

The inclusion of the territories in the Universal Service Rural Health Care Support mechanism, is established in the Universal Service Report & Order issued in 1997, which states: "…the provisions of section 254(h)(1)(A) apply to insular areas because the Act defines 'State' to include all United States Territories and possessions".[19] Moreover, the inclusion of the territories in the support mechanism is consistent with the third Universal Services Principle established in the Telecommunications Act which states: "Access in Rural and High Cost Areas: Consumers *in all regions of the Nation,* including low-income consumers *and those in rural, insular* and high cost *areas,* should have access to telecommunication and information services…that are reasonably comparable … and available at rates that are reasonably comparable to rates charged for similar services in urban areas.[20]

We find that the American Samoa Telecommunications Authority (ASTA) provides a thorough legal analysis regarding the Commission's authority to act upon these two recommendations by making special provisions for the insular areas. ASTA bases its argument on past FCC dockets on the issue, recent related Commission orders and court decisions, and on Senate and Conference report language for Section 254 of the Telecommunications Act.[21] ASTA's interpretation supports the Commission's own conclusion in *Report and Order – Section 11:* "section 254(h)(2)(A) authorizes our

[19] Report and Order – CC Docket No. 96-45, Section IX. B. ¶692.
[20] 47 U.S.C. § 254(b)(3). (emphasis added)
[21] Comments of the American Samoa Telecommunications Authority to the FCC on July 1, 2002 in the Matter of Rural Health Care Support: WC Docket No. 02-60. From S. Conf. Rep. No. 230, 104th Cong., 2nd Sess.1996 ("Conference Report")

adoption of special mechanisms by which to calculate support for the territories…[22] The National Telecommunication and Cooperative Association, while not addressing the insular issue, also argues that the Commission has the authority to designate an "out-of-state" urban area.[23]

ASTA provides documentation from the Act's legislative history to support their interpretation and they also note that in the Joint Explanatory Statement accompanying the Telecommunications Act, "Congress explained that section 254(h) is intended 'to ensure that health care providers for rural areas …have affordable access to modern telecommunications services that will enable them to provide medical …services to *all parts of the Nation.*'" [24] We believe that in order to fulfill congressional intent, the Commission must adopt a mechanism that enables the jurisdictions to participate in the Universal Service Rural Health Care support mechanism in a meaningful way. [25]

ASTA's interpretation that the Commission is authorized under the Act to adopt special mechanisms is strengthened by correspondence to the Commission regarding the insular area issue from the current and former chairs of the Senate Communications Subcommittee, Committee on Commerce, Science and Transportation. On September 21, 1999, Senator Conrad Burns, then Chair of the Communications Subcommittee and Eni Faleomavaega, American Samoa's Representative to the Congress, wrote to the Commission to urge the Commission to designate Hawaii as the nearest urban center for the Pacific Basin flag territories. On September 18, 2001 Senator Daniel Inouye, current chair of the Senate Communications Subcommittee wrote to the Commission urging the Commission to expedite a decision on the matter. Earlier in July of 2001, Congressmen Neil Abercrombie of Hawaii, Eni Faleomavaega of American Samoa and Robert Underwood of Guam and Congresswoman Patsy Mink of Hawaii wrote to the Commission re-iterating the problem with the current rule established for the insular areas, the rational for designating the urban area as Honolulu and requesting an update on the docket as well as expressing hope that the upcoming ruling would address the problem.[26]

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[22] Report and Order – CC Docket No. 96-45, Section IX. B. ¶692.

[23] The National Telecommunication Cooperative Association argues that the Commission has the authority, if a state does not have a city of 100,000, to allow the urban rate to be calculated using the nearest city of 100,000 outside the state. They base their interpretation on the "competitively neutral" language in section 254(h)(2). [Comments of the National Telecommunication Cooperative Association to the FCC on July 1, 2002 in the Matter of Rural Health Care Support Mechanism: WC Docket No. 02-60.]

[24] Comments of the American Samoa Telecommunications Authority to the FCC on July 1, 2002 in the Matter of Rural Health Care Support: WC Docket No. 02-60. From S. Conf. Rep. No. 230, 104th Cong., 2nd Sess.1996 ("Conference Report")

[25] The territories' participation in the E-rate program - the Universal Service support mechanism for schools and libraries – may also be seen as an indication that the Congress intended the territories to be able to also participate in the Rural Health Care program in a meaningful manner. The territories qualify for high discount levels - 78% in Guam, 89% in CNMI and 90% in American Samoa - because of the high levels of poverty.

[26] Letters included in attachments submitted by the Department of Veterans Affairs (DVA) VA Medical and Regional Office Center Honolulu to the FCC on July 19, 2002 in the Matter of Rural Health Care Support Mechanism: WC Docket No. 02-60.

In comments submitted to earlier FCC dockets regarding the issue, all entities commenting have urged the Commission to designate Honolulu as the urban area for the U.S. Pacific Basin territories for the purpose of calculating the telecommunication subsidy under the Rural Health Care program. This includes telecommunications carriers, the Pacific Island Health Officers' Association (PIHOA) which represents all ministers and directors of health in the jurisdictions, and the Federal Office for the Advancement of Telehealth, which has worked with the jurisdictions on telehealth activities and met with the Commission on the issue.[27] All those who have commented on this issue in this current "02-60" docket, have again recommended that the Commission designate Honolulu as the nearest urban center.

In summary, the OPC believes that the mechanism chosen by the Commission to implement the Act in the territories five years ago, while seemingly following the letter of the law in creating a mechanism by which to compare urban and rural rates 'within' a jurisdiction or state, is a mechanism that is not suitable for the jurisdictions, given their geography, isolation and available health resources, and it is a mechanism that does not meet Congressional intent. We believe that the Commission does have the legal authority to re-designate the urban area for the territories and should act to do so immediately. Five years have passed since the program was implemented, yet the Nation's most remote, rural and needy areas have yet to benefit from the program.
Reply comments regarding "Encouraging Partnerships with Clinics at Schools and Libraries."

The Commission seeks comments on "ways in which rules or policies …might be altered to better encourage rural health providers to pool resources with other entities …to limit costs for themselves and thereby utilize support more efficiently", and "whether the Commission's rules and policies may encourage rural health providers to partner with clinics at schools and libraries in rural locations."

As regards school-based clinics, the OPC concurs with the Center for Telemedicine Law, that rural, school-based clinics should be allowed access to the discounts afforded through the schools and libraries program. Allowing a school clinic to utilize the schools and libraries discount would be the most efficient and least burdensome administrative mechanism to implement this. Health services and health education classes are also a recognized part of education. Almost all schools make some provision for providing health services and health education, although the type and amount vary among school districts and states. The goal under the schools and libraries program is to provide access to telecommunications and Internet services to enhance educational services. A healthy student body, ready and able to learn, is a critical part of the equation.

[27] The Office for the Advancement of Telehealth, HRSA, HHS has worked in partnership with the Pacific Basin jurisdictions since 1999 to develop an understanding of telehealth technologies and applications. In addition to funding technology itself, it coordinated its efforts with other entities funding the deployment of technology. In 2001, in anticipation that the Commission would act upon the comments submitted in 1999 under its *Further Notice of Proposed Rulemaking* that addressed the insular issue and the re-designation of an urban area for the territories, it funded each jurisdiction to develop a telehealth plan and to cooperate to develop a Pacific Basin regional plan.

In terms of sharing between schools and clinics, the OPC concurs with PEACESAT's recommendation that programs be allowed to share use of network infrastructure.[28] In many rural communities, and in particular in the Pacific Basin, resources are limited and such multipurpose networks will be a means to avoid duplication and waste, and to enhance network sustainability.

Reply comments regarding "Eligible Services" and "Eligible Health Care Providers":

We are pleased that the Commission has issued this NPR to elicit input on the vital role of telecommunications in responding to national disasters, including the role of a "broader and more fully integrated network of health care providers" in responding to such disasters. Several entities submitted comments addressing these areas, including Kingston eHealth, the National Rural Health Association, and the Minnesota Ambulance Association. They address a range of issues, including discounting Internet services for telehealth, including emergency service providers as eligible providers, and using the Rural Health Care program to help build-out needed infrastructure.

The Committee urges the Commission, as it considers these issues and revises the program, to always remain cognizant of the special issues of insular areas and thereby promulgate rules that address and make sense for not only the 50 states, but also for the U.S. territories. This is necessary to not only ensure that the Universal Service Principles are upheld and fulfilled in the insular areas, but also to ensure that the United States has the strongest possible "chain of defense". As Kingston eHealth notes, a network is only as strong as its weakest link and given the current infrastructure and lack of affordable telecommunication services, the insular areas are one of the Nation's weakest links. It is said that Guam is 'where the American sun rises' and American Samoa 'where it sets'.[29] We urge the Commission to ensure that its telecommunication policies address the Nation's vulnerability in this region.

The Committee's final request is that the Commission act upon the issue of re-designating the "urban center" for the Pacific Basin flag territories as soon as possible. We acknowledge that the Commission will be reviewing all comments and initiating action to address them. However, we are concerned that the Commission may incorporate the issuance of a new rule revising the designation of "urban" for the insular areas with the issuance of revised rules in other areas which are much more complex and which will likely take months, and perhaps years, to work through. The insular areas have waited over five years to have their issue addressed. We therefore respectfully request that the Commission act upon this re-designation issue immediately.

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[28] Comments of PEACESAT [Norman Okamura and Christina Higa] to the FCC on July 2, 2002 in the Matter of Rural Health Care Support: WC Docket No. 02-60.

[29] Guam is the U.S. territory closest to the other side of the international dateline, so the new day begins there for the U.S. and its territories. American Samoa is one of the points furthers west on the other side of the dateline.

Appendix 1

American Samoa

American Samoa is an "unincorporated unorganized" territory[30] of the United States. It lies approximately 2,300 miles southwest of Hawaii and 4,150 miles from the continental United States. It is comprised of six volcanic islands and one coral atoll – Tutuila, Ta'u, Ofu, Olosega, Aunu'u, the Swains and Rose Atoll – and stretches approximately 600 miles in the South Pacific Ocean. Its population of 57,000 (2000 census) is spread across 4 of the islands. The majority live on Tutuila, a 53 square mile island dominated by low, sheer and rugged tropical forest-covered peaks. The settlement pattern is that of coastal villages because of the dense bush and tropical forests. The population of Pago Pago, the capital, is less than 5,000. More than 50% of the population is more than an hour's drive from the hospital, given the island's topography and narrow, windy roads.[31] The population of the Manua island group, 60 miles east of Tutuila, is approximately 900 and the population of the Swains Island is 37. Fishing and tourism are the major industries, and the U.S. government is a major employer. Approximately 60% of all families fall below poverty according to according to the 2000 census.

Health Resources: The only hospital in the territory – LBJ Tropical Medical Center – is located in Pago Pago. It is a 140-bed acute care hospital that, in addition to providing acute care, houses several clinics – pediatric, medical and surgical, OB/Gyn, dental, optometry and dental. It has a small ICU, delivery suite and 3 operating rooms. Basic preventive services are provided by the Department of Health at 5 village dispensaries. The islands of Ta'u and Ofu each have a dispensary staffed by an LPN.

The Department of Veterans Affairs, VAMROC Honolulu has signed a Memorandum of Understanding that is allowing the VA to co-locate its clinic at the hospital.[32] However, affordable telecommunication rates will be needed to enable the clinic to connect with VAMROC Honolulu for telehealth activities.[33]

Health Personnel and Health Professions Education: American Samoa is classified as a Health Professional Shortage Area by the Health Resources and Services Administration, HHS. The overall shortage of professionals is compounded by the difficulty in recruiting and retaining them, including such key professionals as a

[30] It is "unincorporated" because not all provisions of the U.S. Constitution apply to the territory and it is considered "unorganized" because the Congress has not provided the territory with an "organic act". An organic act organizes a government much like a constitution would. Citizens of American Samoa are U.S. nationals, not citizens, although they may become naturalized American citizens. [U.S. Department of the Interior, Office of Insular Affairs, *Fact Sheets August 2000.* www.doi.gov/oia/facts2000.html]

[31] Pacific Island's Health Data Matrix (December 2000) / Pacific Island Health Officers Association

[32] *Report to Congress: Meeting the Pacific Telehealth Challenge*, Department of Veterans Affairs, November 2000.

[33] Comments of the Department of Veterans Affairs (DVA) VA Medical and Regional Office Center Honolulu to the FCC on July 19, 2002 in the Matter of Rural Health Care Support Mechanism: WC Docket No. 02-60.

radiologist. Access to continuing education is very limited. The only institution of higher education in the territory is a community college that offers an associate-degree registered nurse program. However, difficulty in recruiting faculty affects the quality of the educational program and, in the past, graduates have had difficulty passing the licensing exam.

Commonwealth of the Northern Mariana Islands[34] (CNMI)

CNMI, a 14-island group of the Mariana Islands, lies 200 miles north of Guam, 1800 miles south of Japan, and 3,700 west of Hawaii. The Northern Marianas extend about 337 miles from north to south and cover approximately 184 square miles. Only the three largest southern islands are inhabited – Saipan (47 sq. miles), Tinian (39 sq. miles), and Rota (33 sq. miles) and there are transient populations on three of the northern volcanic islands. CNMI's largest town, Garapan (population 3,600) is on Saipan, as well as the towns of Susupe and Capitol Hill, where government offices are housed.

According to the 2000 census, the CNMI population is approximately 57,000, which represents a 22% increase since 1990, a population growth rate that is one of the highest in the world. This growth is primarily due to migration and over 45% of the population are contract workers from the Philippines, China and other Asian countries. The majority of the population lives on the island of Saipan, with approximately 3,300 living on Rota and 3,400 on Tinian. Over 30% of families fall below the poverty level.

Tourism, which had been the leading industry, was hurt in the early 1990's by the Japanese recession, then the Asian economic crisis and most recently by the events of September 11. Because of these events, the garment industry, the only significant manufacturing activity, is emerging as the leading industry. The government is also a major employer. Subsistence farming remains prevalent.

Health Resources: The only hospital in CNMI, the Commonwealth Health Center, is a government-owned and operated 74-bed acute care hospital that provides general acute care and limited ICU/CCU, as well as several outpatient clinics. The Department of Public Health is also responsible for two primary care clinics – one on Rota and one on Tinian, which provide limited primary care and are staffed by mid-level providers with backup from family practitioners. The Department also staffs a Southern Community Health Center and its Division of Public Health provides women and children's clinics, a dental clinic, a chest clinic, and immunizations.

Health Personnel: The compliment of physicians on CNMI are in the primary care specialties of family practice, pediatrics, OB/GYN, internal medicine, surgery and emergency care.[35] There is currently one pathologist. Like American Samoa, CNMI has

[34] The *Covenant to Establish a Commonwealth of the Northern Mariana Islands in Political Union with the United States* was a mutually negotiated document that Congress approved in 1976 and which, when fully implemented in 1986, conferred U.S. citizenship on legally qualified CNMI residents. [U.S. Department of the Interior, Office of Insular Affairs, *Fact Sheets August 2000.]* www.doi.gov/oia/facts2000.html

[35] Pacific Island's Health Data Matrix (December 2000) / Pacific Island Health Officers Association.

had difficulty recruiting and retaining a radiologist and has had to send x-rays to Guam for diagnostic readings. Also like American Samoa, there is no 4-year institution of higher education. A community college provides an associate-degree nursing program and would like to expand to provide additional programs in health. Access to other health career programs would be possible via distance education, but transmission costs are a barrier. Continuing education for CNMI health professionals is also limited and traveling for it is expensive.

Guam

Guam, a territory[36] of the United States, lies at the south end of the Mariana Island group, with the islands of CNMI to its north. It is approximately 1,300 miles east of the Philippines, 3,800 miles west of Hawaii and 9,500 miles from Washington, D.C. Unlike American Samoa and CNMI, Guam is a single island. It covers 209 square miles. The southern half of Guam has a range of mountains, and the flatter northern half, where forests have been cleared, is primarily farmland and includes Anderson Air Force Base. The population of Guam (2000 census) was approximately 155,000, which includes 30,000 military personnel and dependents. Almost a quarter of the population resides in the more rural Southern villages and the rest in the central and northern villages and towns.

Tourism, the has been the mainstay of the Guam economy, has been devastated by the Asian economic crisis of the 90's, Typhoon Paka in 1997, the events of September 11, and most recently by the July 2002 typhoon. These economic downturns have resulted in an unemployment rate of 15%, a rate that has been steadily increasing over the past several years.

Guam is the more developed of the three flag territories and although its health care environment is similar to the United States in many ways, in other respects it resembles a developing country.[37] For example, there are high rates of infectious diseases such as tuberculosis[38], hepatitis B, and infectious skin diseases. Also, within the last two years there have been cases of cholera, Hansen's disease (leprosy), dengue fever, malaria and measles, imported by migrants and visitors.

Health Resources: The Guam Memorial Hospital, the only civilian hospital on Guam, is a 159 acute care-bed hospital.[39] The Guam Department of Public Health and

[36] Guam is an unincorporated, organized territory of the U.S. It is "unincorporated" because not all provisions of the U.S. Constitution apply to the territory. It is "organized" because the Congress provided the territory with an Organic Act in 1950, which also made those born in Guam U.S. citizens at birth. It has been a possession of the U.S. since 1898. Guam has an elected representative to the U.S. Congress who is able to vote in Committee, but not in the whole House. [U.S. Department of the Interior, Office of Insular Affairs, *Fact Sheets August 2000.* www.doi.gov/oia/facts2000.html]

[37] Pacific Basin Regional Telehealth Plan (June 2002 Draft), (p. 17) University of Guam, June 2000.

[38] [45.5/100,000 in Guam compared to the U.S. rate of 6.8/100,000-1998]

[39] The hospital is seeking to regain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Social Services staffs two primary care clinics, one in the southern part of the island and one in the northern part, and also operates a dental clinic. In addition to these public facilities, there are also several private clinics on Guam.

Health Personnel: Guam, like the other flag territories, is plagued by a shortage of health personnel and frequent turnover of staff. Although there is a relatively high number of licensed physicians on the island, Guam is considered a Health Professional Shortage Area and a Medically Underserved Area (MUA) by the U.S. Government. This is especially true for the primary care areas of pediatrics and obstetrics. Specialty care in areas such as orthopedics and dermatology is limited and there is no on-island care in most specialties including gastroenterology, allergy/immunology, pediatric subspecialties, and rheumatology." Because of the lack of specialists, primary care physicians must provide the care that is typically provided by specialists, which further exacerbates the shortage of primary care services. Moreover, maintaining the skills to provide this broad range of care is difficult, given the limited continuing medical education available.[40] [41]

Guam has the only 4-year institution of higher education in the territories and provides a bachelor's level nursing program. In the past it has worked closely with other jurisdictions to provide distance education courses (primarily audio-teleconferencing) for nurses. However, the University has also been affected by the poor economic situation in Guam and maintaining and/or expanding health-related programs will be difficult unless it is able to obtain reasonable telecommunication rates for distance education.

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[40] Pacific Basin Regional Telehealth Plan (June 2002 draft), Pacific Basin Telehealth Consortium, University of Guam.

[41] Although the Guam Memorial Hospital is able to provide some continuing education for physicians and nurses, and makes this available to other jurisdictions, the economic crisis in Guam is making this service increasingly difficult to maintain.